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Using a virtual collaborative care model to improve primary care outcomes

Behavioral health use cases and best practices across the risk spectrum for primary care patients.

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Summary

Success in value-based care is dependent on effectively incorporating behavioral health into the primary care model. The impact of untreated behavioral health conditions on individuals' lives and the cost of health care delivery in the United States is staggering. Persons with any mental illness are more likely to have chronic conditions such as high blood pressure, asthma, diabetes, heart disease and stroke than those without mental illness. Those individuals are also more likely to use hospitalization and emergency room treatment[1]. Behavioral health is intrinsically linked to a patient's ability to successfully manage chronic conditions, monitor their health, maintain a medication regimen, and self-manage their disease. For this reason, primary care is an ideal setting for behavioral health integration to more effectively and proactively manage patients with behavioral health needs. In 2021, more than 8 in 10 mental health professionals reported an increase in demand for mental health services, a spike likely caused by the pandemic[2]. Until now, delivering high-quality behavioral health care in most primary care settings proved to be complex and difficult to execute.

57%

of total health care costs are attributed to patients with > 1 behavioral health condition.

$225B

spent on behavioral health in 2019, a 52% increase in 10 years.

3-6x

average cost for patients with behavioral health diagnoses, compared to those without.

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20% of Americans are affected by mental health disorders. The majority never seek help.

The Challenge

Many patients who could benefit immensely from behavioral health care aren't successful in obtaining care. This is due to access issues, lack of knowledge or recognition about their need for care, or the stigma that exists around mental health care.

Primary care is often a missed opportunity for a behavioral health intervention.

Primary care is a key access opportunity for patients who see their primary care clinician on average once per year. In order to empower primary care to better longitudinally manage patients with behavioral health conditions, we have to address several challenges facing primary care clinicians:

- Lack of behavioral health training
- Time constraints to support patients toward significant improvement
- Limited access to behavioral health specialists in their network

The collaborative care model (CoCM) enables deep clinical integration between primary and specialty mental healthcare, delivering more comprehensive care for patients that improves outcomes and saves money.

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The Solution

RubiconMD BHcare is a collaborative care solution in which a psychiatrist is virtually integrated into a primary care team through the RubiconMD platform.

BHcare can empower primary care clinicians to more effectively manage patients with behavioral health needs. This evidence-based care model is proven to successfully support clinical teams in delivering high-quality, convenient behavioral health care within the primary care setting.

Key areas of projected impact:

Improved Clinical Performance

Reduced Cost of Care

Increase Access for Patients

This paper shares use cases across the risk spectrum and demonstrates the value of an integrated primary care model, utilizing the RubiconMD platform. The platform serves as the central communication hub, on behalf of the patient. This includes a board-certified licensed psychiatrist, a Care Manager, and a patient registry for collaboration between care teams on a secure HIPAA compliant platform. Included with BHcare are training, implementation support, CME education and robust reporting.

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Use Cases

Below are conditions that are ideal for collaborative treatment through this model.

CASE 1: COMMERCIALLY INSURED

- Patient: “Carl”
- Male
- Age 40
- Working father

Typical Primary Care Scenario:

Like 30% of Americans, Carl is affected by insomnia. He has a wife and two children whom he supports by running his own business. He visits his PCP, who administers a PHQ-9 to screen for depression and it is negative. His PCP recommends improving sleep hygiene and trying melatonin.

The visit with the PCP was quick and he was unable to share that he’s experiencing anxiety and marital stress. He isn't able to follow through with the doctor's recommendations and his marriage is struggling. His stress level and lack of sleep worsen. He experiences a panic attack at work so he leaves and drives to the ER.

Note: the patient is on his own to manage his care, his stress levels and anxiety go untreated.

Primary Care with CoCM:

Since Carl is experiencing insomnia, his PCP asks if the Behavioral Care Manager can work with him. His PCP explains that she will conduct a consultation to determine the best course of treatment for Carl. Jennifer (the Care Manager) conducts a screening and evaluation, where she discovers he has a history of anxiety and panic attacks, then meets with the psychiatrist to review Carl's case. Due to his positive response to escitalopram (Lexapro) in the past, the psychiatrist recommends this medication. They advises Carl to improve sleep hygiene, use OTC melatonin, and participate in Cognitive Behavioral Therapy every 2 weeks. Carl is closely monitored and after 4 months, he is much more stable, his marriage improves, and he graduates the care program. Carl’s quality of life significantly improves with CoCM support.

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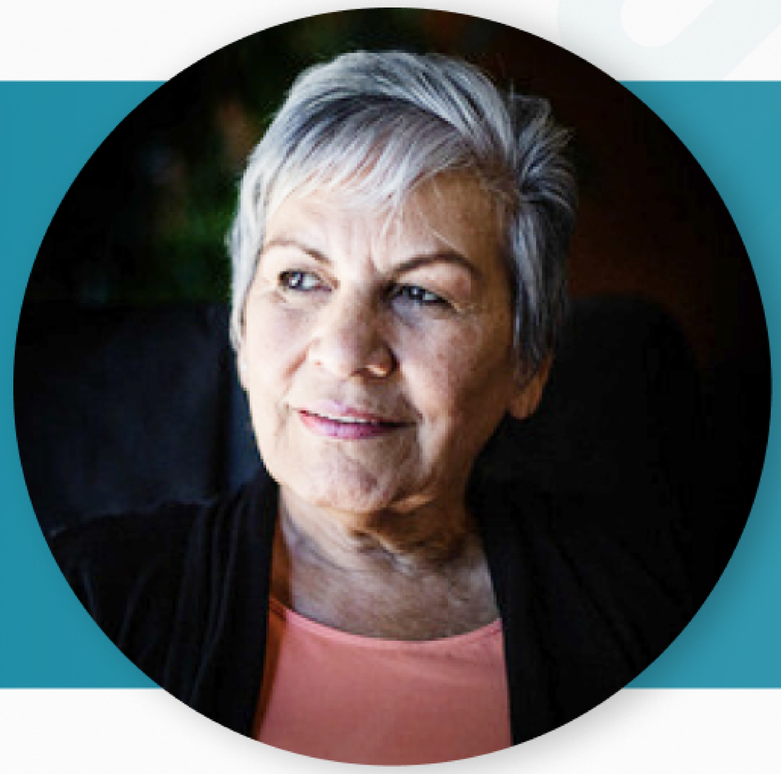
CASE 2: MEDICARE

- Patient: “Marion”
- Female
- Age 70
- Recently widowed



Typical Primary Care Scenario:

Marion recently lost her husband and is living alone for the first time. As her husband’s health declined over the last year, her diabetes coupled with depression and insomnia led to a significant decline in her health. She hasn’t been feeling well or leaving the house for her normal activities with family and friends. She recently had a fall at home that required an ambulance ride to the hospital, resulting in an xray of her arm and stitches on her head. She was visibly upset and shaken after her ER follow-up visit and looked exhausted. The PCP was empathetic to all she had been through over the last year. He updated her treatment plan to get her diabetes stabilized, recommended OTC melatonin for sleep, gave her a referral for counseling, and set up a 3-month follow-up visit. At the 3-month visit, Marion has not connected with the counselor, is worse off in her diabetes outcomes, and is feeling exhausted from her unmanaged diabetes & lack of sleep.

Note: the patient is on her own to manage her care, schedule her referral, and return for follow-up. Her depression is untreated.

Primary Care with CoCM:

The PCP is very concerned about Marion and asks her if she would be willing to meet with Kristen, the Care Manager, who works with his patients who are going through a hard time. Marion agreed and Kristen calls her the next day. She completes a thorough evaluation of Marion’s medical and personal situation. Kristen got consent from Marion to speak to her daughter Betty as well. After completing a comprehensive evaluation, Kristen presented the case to the psychiatrist. The psychiatrist and Kristen establish a working diagnosis of depression and their recommendations includes a grief counseling group for widows, an antidepressant, and OTC melatonin to support Marion through all of the losses, changes and transitions in her life. After 3 months in the care program, Marion continues to grieve the loss of her husband, but she is much more stable and taking her medications. Her diabetes and depression improve and she is sleeping better. The team provides treatment recommendations to the PCP and instructions of when and how to re-refer, if needed. She is discharged from the care program.

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CASE 3: MEDICAID

- Patient: “Edward”
- Male
- Age 58
- Obese, depressed

Typical Primary Care Scenario:

Edward has been a patient at the Federally Qualified Health Center, seeing his primary care physician for two years. He has increasingly gained weight and his most recent labs show that he is pre-diabetic. The scores on his PHQ-9 are getting increasingly worse. The PCP continues to try to work with Edward on setting goals and improving his health and well-being. Over the last several visits, they set the goal together that he would work on his eating habits, try to exercise during the week. He prescribed an antidepressant and a referral for counseling several times to a community program that accepts Medicaid. The PCP is growing frustrated with Edward’s lack of follow-through with his care plan. Edward is increasingly despondent about his situation, embarrassed about his weight and depression, and feels more hopeless after each visit about improving his health.

Note: the patient is on his own to manage his declining health. He lacks the motivation and support to make healthy lifestyle changes. His depression is untreated.

Typical Primary Care Scenario:

The PCP informs Edward about a new program they are offering to help patients with their health in between visits, and he feels that Edward could benefit from more support. He gets Edward’s permission to have Ana, the Care Manger, call him the next day to review his case and discuss how she can help. Edward is embarrassed about his health and depression, but is encouraged by Ana’s call. She spends an hour talking through Edward’s situation in detail. Ana provides psychoeducation and medication instruction, both of which help to address his initial concerns. This motivates him to engage in his care. She finds out that in addition to depression, he has a history of trauma in Colombia before coming to the U.S. He also has a lot of pressure from his family to earn money to send back to Columbia. After review from the psychiatrist, it is recommended that Edward receive supportive counseling, and grounding techniques to manage his trauma. He is also prescribed an antidepressant to address his PTSD. He is feeling much better after 4 months. He is working on eating better and daily movement to lose weight. His PHQ-9 scores are improving. He is discharged from the program and continues to attend the outside support group.

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CoCM Best Practices

These practices are built-in to the BHcare platform

The Collaborative Care Model offers a proven way to integrate behavioral health services into the primary care setting to meaningfully impact outcomes and the patient experience. This can transform chronic care delivery and improve the quality of care for value-based organizations. The following are best practices for executing a Collaborative Care Model:

1. Deliver patient-centered care

The ability to get both physical and mental health care at a familiar location with a trusted clinician boasts several benefits for the patient. It will reduce duplicate assessments and fragmented care while improving the quality of care delivered. This approach has proven to increase patient engagement, likely resulting in a better healthcare experience and improved outcomes. Primary care and behavioral health clinicians collaborate effectively using shared care plans that incorporate patient goals.

2. Maintain a patient registry

When the Care Team shares a defined group of patients tracked in a registry, patients are well managed and gaps in medical records are avoided. Practices can track and reach out to patients who are not improving while mental health specialists provide case-focused consultation, resulting in treatment to target.

3. Utilize evidence-based guidance

The collaborative care model (CoCM) has a substantial evidence base for its effectiveness. Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. An integrated, virtual model improves care and increases access to appropriate, high-quality prevention, treatment, recovery, and wellness services.

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CoCM Best Practices (con't)

These practices are built-in to the BHcare platform

4. Measure patient progress with evidence-based tools

Each patient's treatment plan defines personal goals and desired clinical outcomes. This is routinely measured by evidence-based tools. Treatments are actively revised if patients are not showing improvement as expected until the clinical goals are achieved.

5. Deliver value-based care

By ensuring that behavioral health and physical health services are well integrated and coordinated, higher-value care is delivered. Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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Conclusion

Primary care organizations with a desire to more effectively manage patients with behavioral health needs should consider a virtual care collaborative care model.

The Collaborative Care Model is backed by reliable evidence from multiple studies demonstrating effectiveness in terms of improving access, controlling costs, clinical outcomes, and patient satisfaction. Multiple studies show that having a psychiatrist to provide case load consultation to a Care Manager who coordinates with the PCP and patients is an essential element of the model and correlates with improved outcomes. With a virtual model, there is more ease with staffing, implementation, and training, as well as the benefit of improved speed to care for patients. This model can be integrated and scaled in a variety of primary care settings; rural, urban, and among veterans. It holds the promise to reduce disparities between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions.

Interested in in learning more?

RubiconMD BHcare offers a solution to strategically integrate behavioral care into primary care through technology and a panel of leading behavioral health specialists. Visit rubiconmd.com today to begin the next steps to virtual, collaborative behavioral healthcare:

Needs Assessment

Product Demo

Implementation

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References

1. SAMHSA Behavioral Health Integration Report. (2014). SAMHSA.Gov.https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf
2. https://www.apa.org/news/press/releases/2021/10/mental-health-treatment-demand
3. Collaborative Care for Women With Depression: A Systematic Review. (2017, January 1).ScienceDirect. https://www.sciencedirect.com/science/article/pii/S0033318216300937
4. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care
5. Sanchez, K., Eghaneyan, B., & Mitschke, D. (2014b). Implementation of a collaborative caremodel for the treatment of depression and anxiety in a community health center: results from a qualitative case study. Journal of Multidisciplinary Healthcare, 503.https://doi.org/10.2147/jmdh.s69821
6. Ee, C., Lake, J., Firth, J. et al. An integrative collaborative care model for people with mental illness and physical comorbidities. Int J Ment Health Syst 14, 83 (2020).https://doi.org/10.1186/s13033-020-00410-6

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